U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 12 January 2007

Case No.: 2005-BLA-05792

In the Matter

F.M.
Claimant

v.

BELL COUNTY COAL CORPORATION
c/o JAMES RIVER COAL COMPANY
Employer

and

OLD REPUBLIC INSURANCE CO.
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances: EDMOND COLLETT, Esq.
For the Claimant

GAYLE G. HUFF, Esq.
For the Employer

CHRISTIAN B. BARBER, Esq.
For the Director, Office of Workers' Compensation Programs, U.S. Department of Labor

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On April 28, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, in May 2006, the case was assigned to me. The hearing was held before me in Harlan, Kentucky, on August 22, 2006, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:

(1) the length of the Claimant's coal mine employment;
(2) whether the Employer is properly designated as the responsible operator;
(3) whether the Claimant suffers from pneumoconiosis;
(4) whether his pneumoconiosis, if any, arose from coal mine employment;
(5) whether the Claimant is totally disabled; and
(6) whether the Claimant's total disability, if any, is due to pneumoconiosis.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on July 2, 2001 (DX 2).[1] On February 27, 2003, the District Director issued a proposed Decision and Order awarding benefits (DX 29). The Employer appealed and requested a formal hearing on March 17, 2003 (DX 30). The matter was referred to the Office of Administrative Law Judges, and a hearing was held on May 25, 2004 (DX 35).

After the hearing, held before Administrative Law Judge (ALJ) Daniel F. Solomon, the District Director filed a motion seeking remand to ensure that the Claimant's pulmonary evaluation was complete (DX 35 at 18). The basis for the District Director's motion was that Dr. Baker, the physician who provided the pulmonary evaluation for the Claimant in accordance with §725.406, had relied in part on an invalid pulmonary function study. Although a new pulmonary function study was administered, Dr. Baker did not update his report using the new data. The Claimant joined in the District Director's motion. The Employer opposed the Motion, and also requested to be dismissed from the Claimant's claim, based on its assertion that a remand would prejudice the Employer's interests (DX 35 at 8).

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T" refers to the transcript of the August 22, 2006 hearing.

On August 3, 2004, ALJ Solomon granted the Director's motion and denied the Employer's request to be dismissed from the Claim (DX 35 at 173). The matter was then remanded to the District Director, who contacted Dr. Baker by letter in October 2004 (DX 35 at 5). In his letter, the District Director requested that Dr. Baker assess the following: whether his conclusion that the Claimant had a moderate obstructive defect would change, based on the second (validated) pulmonary function study; whether any impairment is "related to pneumoconiosis or does it have another etiology;" and whether the Claimant retains the respiratory capacity to continue to work as a coal miner. The District Director also specifically requested that Dr. Baker determine, for each respiratory diagnosis, whether such condition was "significantly contributed to, or substantially aggravated by, dust exposure in coal mine employment" (DX 35 at 5).

Dr. Baker responded promptly to the District Director's letter. In his response, he stated that the Claimant has a "chronic lung disease based on legal pneumoconiosis," and has a "moderate, bordering on a severe, obstructive defect." Dr. Baker noted the Claimant's 39 pack-year history of smoking and stated: "It is felt that while the smoking may be the main contributing factor, his 12 to 14 year history of dust exposure may have contributed to some extent. A significant contribution cannot be ruled out nor can it be ruled in due to the differential degree of smoking compared to his coal dust exposure …. He has moderate resting arterial hypoxemia as well as chronic bronchitis."

Dr. Baker went on to state that all of these conditions "have all been significantly contributed to and substantially aggravated by coal dust exposure," and he concluded that the Claimant does not have the respiratory capacity to perform the work of a coal miner or to do comparable work, even in a dust-free environment. He also stated that all of the Claimant's conditions had a material adverse effect on the Claimant's respiratory condition not related to his impairment, "which may be caused largely by his cigarette smoking history but I can not rule out a significant contribution from his coal dust exposure as well. The pertinent fact is how much 12 to 14 years of dust exposure with a negative X-ray would be considered significant in comparison to an approximated 40-pack year history of smoking" (DX 35 at 3-4).

In April 2005, after receipt of Dr. Baker's statement, the District Director again referred the matter to the Office of Administrative Law Judges for a new hearing (CX 36).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in February 1947 and, therefore, he is 59 years old. He is married and has no dependents other than his wife. According to records maintained by the Social Security Administration, the Claimant was employed by coal mine operators as follows (DX 9)[2]. His earnings are rounded to the nearest dollar.

[2] The Claimant's employment by entities other than coal mine operators and in industries other than coal mining are omitted.

Kentucky East Corp., Middlesboro, KY[3] 1970: $4,405; 1971: $4,757; 1972: $2,298	1 Q 1970--2 Q 1972[4]
Premium Coal Co., Inc., Lake City, TN 1974: $1,296; 1975: $1,742	4 Q 1974--1 Q 1975
Davis Construction Co., Inc., Pineville, KY[5] 1975: $10,970; 1976: $8,672	1 Q 1975--3 Q 1976
Billy Ray Carroll Construction Co., Inc., Pineville, KY[6] 1976: $6,900; 1977: $4,589	3 Q 1976--4 Q 1976; 2 Q 1977--3 Q 1977
Billy Ray Carroll, Pineville, KY[7] 1977: $2,951	1 Q 1977
Harlan Fuel Co., Inc., Coalgood, KY 1977: $6,839; 1978: $15,264	3 Q 1977--1978[8]
Bell County Coal Corp., Richmond, VA 1978: $969; 1979: $18,585; 1980: $5,141; 1981: $21,395; 1982: $599	1978--1982

The Claimant's Social Security records also reflect self-employment in 1984 (earning $7,722) and 1985 (earning $10,548).

B. Claimant's Testimony

The Claimant testified under oath at the hearing. He stated that he was about 5 feet eleven inches tall and weighed about 284 pounds, and that his weight had gone up steadily since he suffered an injury in about 1981. The Claimant stated that he has been a smoker for "quite

[3] The location reflected in the Social Security records is not necessarily the location where the Claimant worked; it could be the location of the office responsible for processing payroll or other administrative functions.

[4] The designation "Q" refers to calendar quarter of the year. "1 Q" indicates the first quarter (January-March), etc.

[5] At the hearing, the Claimant testified that this job involved performing maintenance on beltlines at the tipples (T. at 22-23).

[6] At the hearing, the Claimant testified that this employment involved duties similar to his duties at Davis Construction. He stated he did "a little bit of everything," including running dozers and high-lifts, using end-loaders to load coal, and working at the tipple (T. at 24-25).

[7] At the hearing, the Claimant testified that this employment involved the same duties as his work for Bill Ray Carroll Construction Company. He did not explain why the two entities were listed differently on his Social Security records (T. at 26-27).

[8] Beginning in 1978, the Social Security Administration ceased reporting earnings for each calendar quarter and reported yearly earnings only.

awhile" and has smoked approximately a pack of cigarettes a day since 1987. He testified that he has tried to quit a time or two, but that it didn't last more than a few weeks (T. at 11-14).

The Claimant testified that he last worked in 1985, and stated that his self-employment in 1984 and 1985 consisted of hauling coal in his own truck, from several different mine sites. Including his years of self-employment, the Claimant stated that he had about 11 years of coal mine employment. He has worked underground and above ground, and some of his employment consisted of driving a coal truck (T. at 14-15).

The Claimant testified in some detail regarding his employment history, based on the Social Security records, and summarized the types of work he did for each coal mine operator. He testified that his work for the Employer was all underground, and for most of that time he ran a cutting machine, but at one point he was taken off the cutting machine and did dead work and other work. The Claimant stated that the cutting machine was the machine that actually severs the coal from the face, and there was a lot of dust in that job (T. at 16-27).

Regarding his self-employment, the Claimant testified that he was exposed to dust during the times that coal was being loaded into his truck, and also was exposed to rock dust and road dust during the hauling process, either from his own truck or from other trucks on the road (T. at 27-30).

The Claimant testified that he had a back injury while working in the mines, and was beginning to have trouble with his breathing at about the time he was injured. He stated that he has trouble with breathing presently and feels as if he smothers. He sleeps with one pillow, folded, and is up several times at night due to smothering and coughing. He stated that he has a productive cough, is short-winded, and is unable to exert himself (T. at 30-33). The Claimant testified that he is currently being treated by Dr. Perry for his breathing condition. Dr. Perry has prescribed Advair and oxygen, which the Claimant stated he uses mostly at night. The Claimant testified that he has been on oxygen for approximately eight months, and averred that his breathing condition alone prevents him from working in the mines (T. at 33-35).

On cross-examination, the Claimant stated that he did not work for any coal mine operator after his work for the Employer. He recalled that he was laid off in 1980 by the Employer, but was uncertain about how long his layoff was. In 1981, the Claimant testified, he was injured twice. First, he broke his leg in a scoop accident; in the second accident, he hurt his back. He received workers' compensation for these injuries (T. at 36-38).

Responding to questions about his self-employment, the Claimant testified that this work involved hauling coal at deep mine sites to specific locations. He would go to the sites every morning and would haul the coal, generally making four round trips a day. The work was regular, but occasionally there would be a day where there was no hauling. The coal was loaded with an end loader, and the loading was usually done by others (T. at 38-41).

Regarding his employment for Davis Construction, the Claimant stated that Davis did not have a mine of its own, but rather contracted with other mine operators to do "outside work" such as stockpiling coal and fixing belts. His work for Billy Ray Carroll was similar. The

Claimant testified that he worked regularly for the Employer from the time he started until he stopped work in January 1982, except for the times he was injured (T. at 41-46).

In response to my questions, the Claimant stated that he quit working for Davis and began working for Billy Ray Carroll. He stated that, when he was hauling coal, he worked primarily for two different companies, but did not have any written contract. The two companies were owned by brothers-in-law. The Claimant testified that he stopped working in 1985 because of his back problems (T. at 46-51).

The Claimant testified that his breathing started getting worse about four years ago, and he has been seeing Dr. Perry or Dr. Perry's colleague for about 18 years. He stated that Dr. Perry prescribed medication because he started coughing and blacking out, and they told him he wasn't getting enough oxygen in his blood. He was recently hospitalized, and was put on oxygen when he came out of the hospital (T. at 51-54).

On re-cross examination, the Claimant stated that he has been smoking a pack of cigarettes a day since 1987, and also admitted that he began smoking at about age 15. The Claimant also stated that, at that time, he smoked perhaps a cigarette or two a day, because he could not afford more (T. at 55-56).

C. Length of the Claimant's Coal Mine Employment

In this matter, the Employer has controverted the length of the Claimant's coal mine employment, which the District Director determined to be 11 years (DX 36; T. at 9). The purpose of a hearing before an administrative law judge is to resolve contested issues of fact or law. See §725.455(a). Under the governing regulation, if the evidence establishes that a miner worked in or around coal mines during at least 125 working days during a calendar year or partial periods totaling one year, then the Claimant will be considered to have worked one year in coal mine employment. If a miner worked fewer than 125 days in a year, then the miner has worked a fractional year based on ratio of the actual number of days worked to 125. §725.101(a)(32)(i). If the evidence is insufficient to establish beginning and ending dates of a year's employment, then an administrative law judge may divide the miner's yearly income by the amount of the average yearly income for miners for that year reported by the Bureau of Labor Statistics. §725.101(a)(32)(iii).

The Claimant testified that he was exposed to coal mine dust in all of his work for coal mine operators, as well as when he was self-employed hauling coal. See T. at 17, 20, 22, 23, 25, 27, 28). I find that the Claimant's testimony establishes that all of his employment for coal mine operators, as listed above, constitutes coal mine employment. This is consistent with the governing regulation, which defines "miner" to include workers employed in coal mine construction and the transportation of coal, provided they are exposed to coal mine dust as a result of such employment, and that their work was integral to the extraction or preparation of coal. See §725.202(a). Self-employed miners or independent contractors also are considered "miners" under the regulation provided they otherwise meet the requirements of the regulation. §725.202(c). Based on the regulatory definitions and the evidence of record, I also find that the Claimant's self-employment in 1984 and 1985 constitutes coal mine employment.

There is very little evidence of record regarding the beginning and ending dates for each year of the Claimant's coal mine employment. Based on the Bureau of Labor Statistics figures, and employing the method prescribed in §725.101(a)(32), I find that the Claimant's total coal mine employment is 10.3 years. I calculate the Claimant's coal mine employment as follows:[9]

Full years of employment for seven years: 1970, 1975, 1976, 1977, 1978, 1979, and 1981.

Partial years of employment totaling 3.30 years of employment, calculated as follows: 1971: 0.95 year; 1972: 0.41 year; 1974: 0.21 year; 1980: 0.47 year; 1982: 0.05 year; 1984: 0.52 year; 1985: 0.69 year.

No coal mine employment is credited for years before 1970, for the years 1973 and 1983, or after 1985.

D. Designation as Responsible Operator

The Employer has controverted its designation as the responsible operator in the Claimant's case (T. at 9-10). As summarized above, and as reflected in the Claimant's Social Security Administration records, the Employer was the coal mine operator that most recently employed the Claimant directly; the Claimant worked for the Employer between 1978 and 1982, and was not employed by any other operator after 1978 (DX 9). In 1984 and 1985, the Claimant was self-employed. However, I have found that the Claimant's self-employment constituted coal mine employment, and I have also found that the Claimant was self-employed for an aggregate of more than one year.

It is clear that the Employer is an operator, within the meaning of the Act and the governing regulations. The term "operator" is defined in §725.491(a) as "(1) Any owner, lessee, or other person who operates, controls, or supervises a coal mine, or any independent contractor performing services or construction at such mine; or (2) Any other person who: … (iii) paid wages or a salary, or provided other benefits, to an individual in exchange for work as a miner…." Because §725.495 states that the operator responsible for the payment of benefits shall be the potentially liable operator that most recently employed the miner, the designation of "responsible operator" is thereby limited to those entities that may be designated as "potentially liable operators." §725.494. A "potentially liable operator" must have been an operator for any period after June 1973 (§725.494(b)); must have employed the miner for a cumulative period of not less than one year (§725.494(c)); must have employed the miner for at least one day after December 1969 (§725.494(d)); and must be capable of assuming financial liability for the payment of benefits (§725.494(e)). An operator who supervises the work of the miner, or who benefited from such work, may be considered a potentially liable operator, notwithstanding the fact that the operator was not the miner's formal employer. §725.493(b)(2).

[9] §725.101(a)(32) requires that the Bureau of Labor Statistics table of average coal mine employment wages be included in the Claimant's record, if this method is used. The relevant table is in the record at DX 23.

Under the regulation, the designated responsible operator has the burden to prove either that it does not possess sufficient assets to secure the payment of benefits, or that it was not the potentially liable operator that most recently employed the miner. Such proof "must include evidence that the miner was employed as a miner after he or she stopped working for the responsible operator and that the person by whom he or she was employed is a potentially liable operator …. The designated responsible operator must demonstrate that the more recent employer possesses sufficient assets to secure the payment of benefits in accordance with §725.606." §725.495(c)(2).[10]

The evidence adduced at the hearing indicates that, after his employment with the Employer terminated, the Claimant was self-employed as a contractor for more than one coal mine operator. See T. at 39-42. As set forth above, the Claimant was self-employed during 1984 and 1985, and his total earnings from self-employment constituted more than one year of coal mine employment. However, based on the length of the Claimant's self-employment, his total earnings, and his testimony regarding the division of his work between the two operators, I find that neither of these operators could be deemed to be a "potentially liable operator" because neither can be construed to have employed the Claimant for one year or more.

Based on the above, I find that the Employer is the potentially liable operator that most recently employed the Claimant. Consequently, I find that the Employer was properly designated as the responsible operator.

E. Relevant Medical Evidence

In his affirmative case, the Claimant presented a medical report from Dr. Truman Perry, his treating physician, dated July 2002 (DX 15). The Claimant also submitted medical treatment records from Dr. Perry, covering the period between 1997 and 2002 (DX 13), and records of hospitalization and medical treatment from Baptist Regional Hospital, in Corbin, Kentucky, which cover the years from 2004 to 2006 (CX 1). In addition, the Claimant submitted the curriculum vitae of Dr. Glen Baker, the physician who performed the Claimant's pulmonary evaluation under §725.406 (CX 2).

The Employer presented, in its affirmative case, medical reports from Dr. Abdul Dahhan, dated April 2003 and July 2006 (DX 35 at 147 and EX 1), which included results from the chest X-ray, pulmonary function test, and arterial blood gas test Dr. Dahhan administered in September 2002. The Employer also submitted a medical report from Dr. Ben Branscomb, dated April 2004 (DX 35 at 120) and a medical report from Dr. David Rosenberg, dated July 2006 (EX 2). Lastly, the Employer submitted Dr. William Kendall's interpretation of the X-ray that Dr. Dahhan administered in September 2002 (DX 35 at 166).

[10] Under §725.495(d), in any case referred to the Office of Administrative Law Judges for hearing in which the designated responsible operator is not the operator that most recently employed the miner, the record must contain a statement from the District Director explaining such designation. Such a statement appears in the record at DX 29.

To rebut the Director's interpretation of the X-ray that Dr. Baker administered as part of the pulmonary evaluation under §725.406, the Employer submitted an X-ray interpretation by Dr. Alexander Poulos of that same X-ray (DX 13 at 112).

These items will be discussed in greater detail below.

F. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. §718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence; (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, §718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§718.202(a)(1) through (a)(4):

(1) X-ray evidence: §718.202(a)(1).
(2) Biopsy or autopsy evidence: §718.202(a)(2).
(3) Regulatory presumptions: §718.202(a)(3).[11]

[11] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to

(4) Physician opinion based upon objective medical evidence: §718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with §718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis.

The current record contains the following chest X-ray evidence:[12]

Date of X-Ray	Date Read	Ex.No.	Physician	Radiological Credentials[13]	Interpretation
09/19/2001	09/19/2001	DX 14	Baker	None[14]	ILO: 0/1 (3 zones)
09/19/2001	04/06/2004	DX 35 at 96	Poulos	BCR, B reader	Negative
09/10/2002	09/10/2002	DX 35 at 165	Dahhan	B reader	Negative
09/10/2002	12/01/2003	DX 35 at 166	Kendall	BCR, B reader	Negative

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight

---

pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§718.306).

[12] At DX 35, the record also contains additional X-ray interpretations. I did not consider these interpretations because neither party proffered them.

[13] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. §37.51 for a general description of the B reader program.

[14] Dr. Baker currently is certified as a B reader. However, he was not certified at the time he interpreted the Claimant's X-ray. See infra at footnote 15. This X-ray study was also read by Dr. Nicholas Sargent, a Board-certified radiologist and B reader, for quality control purposes only. Dr. Sargent did not contradict Dr. Baker's interpretation (but did note his disagreement with Dr. Baker regarding film quality). See DX 14.

than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

In this case the record consists of two chest X-rays of the Claimant, and each of those X-rays was interpreted twice. One interpretation of each X-ray was made by a dually-qualified physician (Board-certified radiologist as well as B reader). Of the remaining interpretations, one was made by a B reader, Dr. Dahhan; the other was made by Dr. Baker, who at the time was not certified as a B reader.

None of the X-ray interpretations are positive for pneumoconiosis. Based upon multiple negative interpretations, including interpretations made by dually-qualified physicians, I find that the Claimant is unable to establish, by means of X-ray, that he has pneumoconiosis.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. §718.202(a)(2). That method is not available here, as the current record contains no such evidence.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under §718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under §718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. As stated above, the definition in §718.204(a) of pneumoconiosis includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis, and so a physician opinion may be expected to discuss either "clinical" pneumoconiosis, or "legal" pneumoconiosis, or both.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following medical opinions:

Dr. Glen Baker (DX 14, DX 35, CX 2)

In September 2001, Dr. Baker, who is Board-certified in internal medicine and pulmonary medicine and is a B reader,[15] conducted a pulmonary evaluation under §725.406, in conjunction with the Claimant's instant claim. His evaluation included conducting a physical examination, taking a medical and work history, and administering various tests, including a chest X-ray, a pulmonary function test, and an arterial blood gas test. Following the evaluation, Dr. Baker submitted a written report.

Dr. Baker's report noted the Claimant's work-related back injury and reflected that the Claimant reported daily sputum production, cough, wheezing, and dyspnea for 10 years, and that his shortness of breath got better after coughing up phlegm. Dr. Baker's physical examination of the Claimant appeared to be essentially normal, as the report noted no physical abnormalities. The report, which was based on a work history of 12-14 years and a smoking history which began at age 15 and consisted at present of 1 pack per day, indicated that Dr. Baker diagnosed the Claimant with the following: chronic obstructive pulmonary disease (COPD), based on pulmonary function test results; chronic bronchitis, based on history of cough, sputum production and wheezing; and hypoxemia, based on the arterial blood gas test results. Dr. Baker attributed all these conditions to "cigarette smoking/coal dust exposure." In response to a pre-printed question, "Based upon your examination, does the miner have an occupational lung disease which was caused by his coal mine employment," Dr. Baker responded: "No" (DX 14).

Dr. Baker's follow-up response to the District Director is summarized above. In that response, which reiterated the three diagnosed pulmonary conditions, Dr. Baker attributed the Claimant's pulmonary impairments to his smoking as well as his coal mine employment. He pointed out that the Claimant's smoking history was far more extensive than his coal mine employment; nevertheless, Dr. Baker stated that he "can not rule out a significant contribution from coal mine dust exposure as well," citing the Claimant's 12 to 14 year coal mine employment history.

[15] The record reflects that Dr. Baker was generally certified as a B reader from 1988 to 2006, but that he was not certified for the periods November 1992 to January 1993 and February 2001 to May 2002. The record contains no explanation for these gaps in certification. See CX 2.

Dr. Truman Perry (DX 15, DX 13)

In July 2002 Dr. Perry submitted a report to the District Director with his assessment of the Claimant's physical condition (DX 15).[16] This report, which reflects that Dr. Perry has been the Claimant's physician since 1999, includes a diagnosis of COPD, as well as several other non-pulmonary diagnoses (such as degenerative disc disease).[17] Dr. Perry noted that the Claimant had the following symptoms: shortness of breath, wheezing, rhonchi, episodic acute bronchitis, fatigue, and coughing. In response to pre-printed questions, Dr. Perry opined that the Claimant's pulmonary disease was caused, at least in part, by exposure to coal mine dust, and he cited arterial blood gas and pulmonary function test results as the basis for his diagnosis (DX 15).

The Claimant also submitted 18 pages of handwritten medical treatment records from Dr. Perry, covering the period between October 1997 and May 2002 (DX 13). These records focus on the Claimant's back problems but reflect that he was treated several times for COPD and acute bronchitis over this time period, and that Dr. Perry prescribed nebulizer and inhaler medications. No medical tests relating to the Claimant's pulmonary condition are reflected in these records.

Medical treatment and hospitalization records (DX 13; CX 1)

As summarized above, the Claimant presented medical treatment records from Dr. Perry (DX 13). In addition, the Claimant presented 24 pages of medical treatment records chronicling the Claimant's treatment at Baptist Memorial Hospital, in Corbin, Kentucky, during 2004 and 2005. These records reflect primarily the Claimant's treatment for COPD, and indicate that the Claimant was admitted to the hospital for several days in September 2005 for "COPD exacerbation." Several arterial blood gas test results, from the time of his hospitalization and afterward, are included in these treatment records (CX 1). The records indicate that the Claimant treated with several prescription medications, including Advair, Albuterol, and Proventil.

Dr. Abdul Dahhan (DX 35 at 147; EX 1)

At the request of the Employer, Dr. Dahhan, who is Board-certified in internal medicine and pulmonary medicine and is a B reader, conducted a medical evaluation of the Claimant in September 2002. Dr. Dahhan's evaluation included conducting a physical examination, taking a medical and work history, and administering various medical tests, including a chest X-ray, pulmonary function test, and arterial blood gas test.

In April 2003, Dr. Dahhan submitted a written report. This report reflects that Dr. Dahhan also reviewed other medical reports pertaining to the Claimant, including Dr. Perry's office notes and July 2002 report and Dr. Baker's pulmonary evaluation.[18] On physical

[16] Dr. Perry's professional credentials are not included in the record.

[17] According to the Claimant, Dr. Perry has been his treating physician for approximately 18 years (T. at 33, 52).

[18] I disregarded Dr. Dahhan's mention of X-ray interpretations that were not proffered by the parties.

examination, Dr. Dahhan noted "increase AP diameter of the chest" and "scattered expiratory wheeze." Test results indicated an obstructive ventilatory defect with moderate response to bronchodilators, hyperinflated lungs on X-ray.

In his report, which presumes a coal mine employment history of 12 years and a smoking history of a pack per day, beginning at age 12, Dr. Dahhan opined that the Claimant had "chronic obstructive airways disease," and that there was insufficient evidence to conclude that the Claimant had coal workers' pneumoconiosis. Dr. Dahhan also stated that the Claimant's obstructive ventilatory defect was not caused by or contributed to by coal dust exposure or coal workers' pneumoconiosis, and attributed the Claimant's condition to his 40 pack year history of smoking. Dr. Dahhan noted that the Claimant had not had any exposure to coal mine dust since 1980, a duration sufficient to cause cessation of any industrial-related bronchitis. Dr. Dahhan also remarked that the Claimant's response to bronchodilator therapy was "inconsistent with the permanent adverse affects (sic) of coal dust on the respiratory system," and cited the fact that the Claimant was being prescribed bronchodilating medications by his physician as additional evidence that the Claimant's condition was responsive to such treatment (DX 35 at 147-150).

In July 2006, Dr. Dahhan submitted a second medical report, which reflected that he had reviewed additional medical information on the Claimant developed since his prior report, including Dr. Baker's follow-up letter to the District Director, treatment records from Baptist Medical Center, and several X-ray interpretations. In this report, Dr. Dahhan reiterated the same conclusions that he made in his earlier report, and also stated that since the Claimant's ventilatory impairment did not arise from either inhalation of coal mine dust or coal workers' pneumoconiosis, there was no evidence that the Claimant had legal pneumoconiosis. Dr. Dahhan also noted that Dr. Baker did not address the issue of the Claimant's response to bronchodilators, or the fact that the Claimant had not had any exposure to coal dust since 1985 yet continued to smoke (EX 1).[19]

Dr. Ben Branscomb (DX 35 at 120)

The Employer presented a medical report from Dr. Branscomb, dated April 2004. Dr. Branscomb, who is Board-certified in internal medicine and is a B reader, is an emeritus professor of medicine at the University of Alabama at Birmingham. An endowed chair in respiratory disease was created in his honor in 1990.

Dr. Branscomb reviewed various records relating to the Claimant, including Dr. Baker's and Dr. Dahhan's medical reports (including associated test results) and Dr. Perry's medical records. Dr. Branscomb's report indicated that the Claimant had been credited with nine to ten years of coal mine employment, ending in 1985, but he apparently discounted the Claimant's self-employment and determined that the Claimant had eight years of such employment, ending in 1981. Although Dr. Branscomb described this level of dust exposure as "decidedly light," he

[19] The first two pages and the first two paragraphs of the third page of Dr. Dahhan's report duplicate his earlier report. I disregarded these portions of his report. Dr. Dahhan's July 2006 report is admissible under §725.414(a)(3)(ii), as a response from a physician who submitted a medical report to additional evidence.

presumed that the amount of the Claimant's exposure was sufficient to subject him to adverse effects. Dr. Branscomb also noted that the records reflected that the Claimant smoked cigarettes and had been a smoker since age 15. He characterized this level of exposure as "exceedingly heavy," and stated that pulmonary and cardiovascular manifestations would be extremely common based on that level of exposure.

Based upon physical findings evidenced in the medical records, Dr. Branscomb determined that the Claimant had COPD.[20] He stated that "there is a possibility that coal mine dust exposure has been sufficient to cause some medical problem although the exposure has been light. The smoking history is devastatingly severe, an exposure at which one would expect COPD and other pulmonary problems would be highly likely."[21] Dr. Branscomb concluded that the Claimant had "mild to moderate COPD caused by cigarette smoking," and that he has no respiratory impairment caused, or aggravated to any significant degree, by coal mine dust exposure. Dr. Branscomb acknowledged that dust-related pulmonary disease can be latent, not appearing until after coal mine employment ceases; however, he noted that the scientific evidence has established the relationship between smoking and COPD, with the degree of reversibility that the Claimant evidenced. On the other hand, Dr. Branscomb stated:

> [t]he studies on airways obstruction related to coal mine employment show neither the level of reversibility seen in [the Claimant] nor do they show the time sequence with onset many years after ceasing his last truck driving job …. There is no documentation in the literature that any "legal" pneumoconiosis such as aggravation of COPD could occur fifteen years or so after retiring from coal mine work. Further, the attribution of COPD to the continued almost lifelong tobacco exposure is overwhelmingly clear. There are certain situations in which manifestations of CWP [coal workers' pneumoconiosis] can worsen after mining stops …. There are, however, no examples of latency in progression for dust exposure that would apply to the problem in [the Claimant], given the timing of the exposures and the nature of the pulmonary manifestations.

Dr. David Rosenberg (EX 2)

The Employer presented a medical report dated July 2006 from Dr. Rosenberg, who is Board-certified in internal medicine, pulmonary medicine, and occupational medicine and is a B reader. Attached to Dr. Rosenberg's report was a "Notice of Filing Employer's Exhibit 2," in which the Employer averred that the circumstances warranted admission of Dr. Rosenberg's report, based on the "good cause" requirement of §725.456(b)(1). The Employer stated that Dr. Branscomb had retired, and that he was therefore not available to prepare an addendum to his 2004 report. Since 2004, the Employer noted, the Claimant's claim had been remanded to the District Director for the development of additional evidence (i.e., Dr. Baker's response), and both parties had developed additional evidence; according to the Employer's Notice of Filing, it

[20] Dr. Branscomb also noted that excessive weight, such as the Claimant's records reflected, could create respiratory difficulties, but did not specifically attribute any pulmonary impairment in the Claimant's case to his excessive weight.

[21] Although Dr. Branscomb presumed less coal mine employment than I have found, I find that his is immaterial, as Dr. Branscomb also specifically stated that the Claimant's level of dust exposure was sufficient to cause adverse effects.

should have the opportunity to submit a new review of evidence developed since the time the Claimant's claim was remanded. The Claimant did not object to the admission of Dr. Rosenberg's report (T. at 6).

In general, §725.414 prescribes evidentiary limitations for black lung benefits cases adjudicated under the current regulations. Each party may submit, in support of its affirmative case, no more than two medical reports. §725.414(a)(2)(i) and §725.414(a)(3)(i). A medical report is defined as a "physician's written assessment of the miner's respiratory or pulmonary condition." §725.414(a)(1). Where a party has submitted evidence tending to undermine the conclusion of a physician who prepared a medical report, the party who submitted the medical report shall be entitled to submit an additional statement from the physician who submitted the report which explains his or her conclusion in the light of the new evidence. See, e.g., §725.414(a)(2)(ii).

In this case, Dr. Branscomb, who submitted a medical report on behalf of the Employer in 2004, is retired; therefore, he is not available to submit an "additional statement" explaining his report in light of new evidence. I find that such a circumstance constitutes "good cause" for the Employer to submit additional medical evidence. However, I also find that the Employer is limited to a report that addresses new evidence, as the Employer would be entitled to do under §725.414(a)(2)(ii). Were Dr. Branscomb to be available, the factual circumstances of this case would not constitute "good cause" for the Employer to produce a third full medical report; rather, the Employer would be limited to obtaining a report from Dr. Branscomb addressing the evidence developed since the time the matter was remanded, which is the process the Employer used to obtain an updated medical report from Dr. Dahhan (See EX 1).

Dr. Rosenberg's report consists of a review of medical records pertaining to the Claimant. Its scope is not limited to matters that fall within the parameters of §725.414(a)(3)(ii), such as evidence or records developed or submitted since the time that the matter was remanded to the District Director (in August 2004) or the date of Dr. Branscomb's report (April 2004). For example, Dr. Rosenberg's report discusses Dr. Dahhan's April 2003 medical report, as well as multiple X-ray interpretations, some of which have not been submitted by the parties for my consideration. Notably, Dr. Rosenberg did not address Dr. Branscomb's conclusions, and it appears that he did not review Dr. Branscomb's report.

Because I am bound by the evidentiary limitations set out in §725.414 regarding admission of medical evidence, I am unable to consider items which exceed those limits. The Claimant's lack of objection to my consideration of such matters does not waive the regulatory limitations. Smith v. Martin Valley Coal Corp., 23 B.L.R. 1-69 (2004). Consequently, I will consider only those portions of Dr. Rosenberg's report which discuss evidence developed or submitted since the date of Dr. Branscomb's April 2004 report, which are the transcript of the earlier hearing, Dr. Baker's October 2004 statement to the District Director, and the treatment records from Baptist Medical Center.

In his report, Dr. Rosenberg concluded that the Claimant did not have coal workers' pneumoconiosis, and while the Claimant did have COPD, his COPD was caused by cigarette smoking and was not related to exposure to coal mine dust. Dr. Rosenberg cited scholarly

publications setting forth patterns of pulmonary impairment related to occupational dust exposure, and he remarked that the Claimant's impairment is not consistent with such disease.

Discussion

The regulation recognizes that a physician opinion may conclude that a miner has pneumoconiosis, notwithstanding a negative X-ray. §718.202(a)(4). In the Claimant's case, there is no X-ray interpretation supporting a finding of pneumoconiosis, and no physician has opined that the Claimant has clinical pneumoconiosis. However, all of the physicians of record who have provided medical opinions in the Claimant's case have determined that the Claimant has chronic obstructive pulmonary disease (COPD). These physicians' opinions are based on medical test results, principally the Claimant's pulmonary function test results. Because the medical opinions regarding the Claimant's pulmonary ailment are unanimous, and all are based on objective medical findings, I find that the Claimant has COPD.[22]

The regulation recognizes that a chronic pulmonary condition, including COPD, "arising out of coal mine employment" is considered to be "legal pneumoconiosis." §718.201(a)(2). The regulation defines the term "arising out of coal mine employment" any chronic pulmonary impairment "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." §718.201(b). The burden to establish the causal link between coal mine employment and the pulmonary impairment remains with the Claimant. See Anderson v. Director, OWCP, 455 F.3d 1102 (10th Cir. 2006).

Four physicians – Dr. Baker, Dr. Perry, Dr. Dahhan, and Dr. Branscomb – have provided medical opinions regarding the Claimant's condition. All of these physicians also recognize that the Claimant's smoking history played a role in his pulmonary condition. Under the regulation, it is crucial to assess the effects of smoking as opposed to the effects of coal dust exposure in contributing to the Claimant's condition, because the Claimant's condition is considered to be pneumoconiosis only if it is "significantly related to" or "substantially aggravated by" his coal dust exposure.

Of the four opinions, Dr. Perry's opinion is on the etiology of the Claimant's COPD is the least helpful. Dr. Perry states only that both tobacco use and coal dust exposure are factors. He does not assign relative weights to those factors, and he does not discuss how he is sure that both factors played a role in the Claimant's condition. I note that, although Dr. Perry is the Claimant's treating physician, he did not treat the Claimant at the time the Claimant was still working as a miner. Though he cited medical tests as the basis for his conclusion, Dr. Perry's opinion did not explain how those test results led him to his determination. Because Dr. Perry's opinion is conclusory, and not does address the issue of the relative importance of the two factors, smoking and dust exposure, I find it not to be well-reasoned, and I give it little weight.

[22] An examination of Dr. Rosenberg's conclusions indicates, however, that they were based on Dr. Rosenberg's assessment of evidence contained in all the records he examined, and were not limited to an analysis of the newly-developed evidence. I find that I am unable to discern which, if any, of Dr. Rosenberg's comments are based solely on the newly submitted evidence. Consequently, I disregard Dr. Rosenberg's conclusions, and I assign them no weight.

Like Dr. Perry, Dr. Baker opined that both coal dust exposure and cigarette smoking played roles in the Claimant's pulmonary impairment. However, Dr. Baker also opined that the Claimant did not have an occupational lung disease caused by his coal mine employment. This statement is conclusory, similar to Dr. Perry's, and I consequently give it little weight. In his later statement to the District Director, Dr. Baker expanded on his conclusion: he opined that cigarette smoking played a role in the Claimant's condition but also stated that a contribution from dust exposure could not be ruled out or ruled in. I find Dr. Baker's statement to be well-reasoned, and I give it significant weight. Dr. Baker's statement does not establish that coal dust exposure played a significant role in the Claimant's condition. Quite the contrary: Dr. Baker's statement indicates that he cannot determine that there is any contribution from dust exposure at all, much less that there is a significant contribution. Consequently, I infer from Dr. Baker's statement that he can establish no causal link between dust exposure and the Claimant's COPD.[23]

Dr. Dahhan determined that the Claimant had COPD but had no restrictive pulmonary disease. He also concluded that the Claimant's COPD was not linked to coal mine employment, and pointed out that the Claimant demonstrated a significant response to bronchodilators in his pulmonary function test, which in his opinion was inconsistent with the permanent adverse effects of coal dust on the respiratory system. However, Dr. Dahhan did not address the fact that, even after bronchodilator use, the Claimant showed a significant degree of disability, and Dr. Dahhan did not draw any conclusions about the etiology of this underlying impairment. Because Dr. Dahhan's conclusions do not fully address the Claimant's condition, I find his opinion not to be well-reasoned, and I assign it little weight.

Dr. Branscomb determined that the Claimant's COPD was due primarily to his cigarette smoking. He did not discount that there might be a contribution from dust exposure in the Claimant's case, but he concluded that any contribution was not significant. Dr. Branscomb's opinion explicitly recognized that dust-related illnesses can be latent (as the regulation states at §718.201(c)). However, he noted also that in the Claimant's case a latent dust-related impairment is unlikely, because his dust exposure was quite remote in time and the "attribution of COPD to continued almost lifelong tobacco exposure is overwhelmingly clear," and he states that the scientific literature shows no instances similar to the Claimant's, given his period of latency and his pattern of pulmonary impairment.

I find Dr. Branscomb's opinion to be well-reasoned and persuasive, and I give it significant weight. Dr. Branscomb's opinion recognized that the Claimant's dust exposure history could create pulmonary impairment, but discounted that it did, based on the Claimant's

[23] I also note that Dr. Baker's conclusion was based on the assumption that the Claimant had a 12 to 14 year history of coal dust exposure. As set forth above, I have found that the Claimant has 10.3 years of coal mine employment. The difference between 10.3 and 12 years of employment is a little more than 10 percent (1.7 years), and is probably not critical. However, the difference between 10.3 and 14 years of employment, 3.7 years, is about 33 percent, which is significant. The fact that Dr. Baker over-credited the Claimant's coal mine employment history makes his conclusion, that a link between the Claimant's coal dust employment and his COPD is not established, even more reliable.

level of impairment and his extremely heavy smoking history. Similarly, Dr. Branscomb recognized that pneumoconiosis can be latent, but determined that there was no manifestation of a latent impairment in the Claimant's case, based on the Claimant's impairment and the scientific literature. I am most impressed with the manner in which Dr. Branscomb related general principles, such as latency, to the Claimant's case by referring to the facts of the Claimant's pulmonary impairment.

In conclusion, therefore, I give more weight to the well-reasoned opinions of Dr. Baker and Dr. Branscomb than I do to the opinions of Dr. Dahhan and Dr. Perry, which are not well-reasoned. Neither Dr. Baker nor Dr. Branscomb concluded that the Claimant's COPD was significantly related to the Claimant's coal mine dust exposure. Although Dr. Perry did opine that coal mine dust exposure played a role, he did not explain the basis for his conclusion, nor did he determine that coal mine dust played a significant role in the Claimant's COPD.

I find, therefore, that the Claimant is unable to establish that he has pneumoconiosis based on physician opinion. The Claimant is unable to establish that his COPD arose from coal mine employment, as defined in §718.201(b). Consequently, upon examining all of the evidence, I also find that the Claimant is unable to establish, by a preponderance of evidence, by any means recognized in §718.202, that he has pneumoconiosis, as defined in §718.201.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. §718.203(b). As discussed above, I have found that the Claimant has established 10.3 years of coal mine employment. Therefore, he is entitled to invoke the rebuttable presumption.

However, as set forth above, I have found that the Claimant was unable to establish that he has pneumoconiosis. Therefore, he is unable to benefit from the rebuttable presumption.

c. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. §718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. §718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. §718.204(b)(2)(iv).

Pulmonary Function Tests

The record contains the following pulmonary function test results. Where two values are listed, the second indicates measurements taken after a bronchodilating agent was administered.

Date of Test	Physician	FEV_1	FVC	MVV	FEV_1/FVC ratio	Valid ?
09/19/2001	Baker	1.58	3.56	55	44%	No[24]
12/13/2001	Baker	1.58	3.81	54	41%	Yes[25]
09/10/2002	Dahhan	1.42/1.84	2.84/3.72	34/49	50%/49%	Yes[26]

In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. §718.204(b)(2)(i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The records reflect the Claimant's height at 70 ½ inches or 179 centimeters, which equates to 70.5 inches. The Claimant was born in February 1947, so he was 54 years old at the time of the tests Dr. Baker administered, and 55 years old at the time of the tests Dr. Dahhan administered. At age 54, the qualifying FEV_1 value for a male 70.5 inches tall is 2.19, and the qualifying value is 2.17 at age 55. The qualifying FVC values are 2.77 at age 54 and 2.75 at age 55, and the qualifying MVV values are 88 at age 54 and 87 at age 55.

[24] This test was invalidated by Dr. Burki on October 27, 2001, based on Dr. Burki's determination that "curve shapes [of flow-volume loops] indicate suboptimal effort" (DX 14). Dr. Baker's report indicates that the Claimant's cooperation was "fair" (DX 14).

[25] This test result was validated by Dr. Michos, who is Board-certified in internal medicine and pulmonary medicine, on January 7, 2002 (DX 14). Dr. Baker's report indicates that the Claimant's cooperation was "fair" (DX 14). Dr. Branscomb, however, questioned the validity of the test, at least regarding the MVV value (DX 35 at 122).

[26] Dr. Branscomb has questioned the validity of this test. See DX 35 at 123-24.

Based on the tests listed above, the Claimant has obtained qualifying FEV_1 values on all the pulmonary function tests. His FVC values are not qualifying, nor are his MVV values. However, for all tests the FEV_1/FVC ratio is qualifying, because the ratio is less than 55%.

The first test Dr. Baker administered was invalidated by Dr. Burki, a consultant for the Department of Labor. The second test Dr. Baker administered was validated by Dr. Michos, another Department consultant. However, Dr. Branscomb called into question the validity of this test. Assuming arguendo that the tests Dr. Baker administered are not valid, I am not required to disregard them. Under the governing regulation, Appendix B to part 718, if one or more standards for administration of pulmonary function tests are not met, I may consider the evidentiary weight of such tests in making my determination.

The record does not contain any pulmonary function test result with nonqualifying values. I note that the values Dr. Dahhan obtained are similar to the values that Dr. Baker measured. Therefore, based on these parallel results, I find that Dr. Baker's tests have some degree of reliability, although not as great as Dr. Dahhan's. I do not disregard Dr. Baker's tests, but I give them less weight than Dr. Dahhan's tests. I note also that Dr. Baker did not administer a bronchodilating agent, and Dr. Dahhan did. Although, as Dr. Dahhan notes, the Claimant demonstrated a significant response to the bronchodilators in that the scores showed less pulmonary impairment, I note (as Dr. Dahhan did not) that the Claimant obtained qualifying values even after bronchodilator administration.

Based on the pulmonary function test results, therefore, I find that the Claimant has established that he is totally disabled, from a pulmonary standpoint.

Arterial Blood Gas Tests

The record contains the following arterial blood gas test results:[27]

Date of Test	Physician	PCO_2	PO_2	PCO_2 (post-exercise)	PO_2 (post-exercise)
09/19/2001	Baker	42	65	Not done	Not done[28]
09/10/2002	Dahhan	43.2	60	Not done	Not done[29]

[27] The Claimant's hospitalization records at CX 1 also referred to additional arterial blood gas test results. I disregarded reference to arterial blood gas tests taken in conjunction with the Claimant's hospitalization, as these tests were diagnostic, related to the Claimant's acute illness (exacerbation of COPD), and not indicative of his usual condition.

[28] The record reflects that an exercise test was medically contraindicated due to degenerative joint disease ("DJD") of the back. Under the regulation, an exercise blood gas test shall be offered unless medically contraindicated. §718.105(b). Under the circumstances described in the record, where the Claimant had medical conditions of a non-pulmonary nature that made exercise difficult, I find that an exercise blood gas test was contraindicated.

[29] The record reflects that the Claimant stated that he was unable to take an exercise test due to back problems (DX 135 at 163).

12/22/2005	Perry *	43.4	58	N/A	N/A
03/02/2006	Perry *	47.4	53	N/A	N/A

* These test results were included in medical treatment records at CX 1.

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. §718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

The record establishes that the altitude at which Dr. Baker administered the Claimant's arterial blood gas test was less than 2999 feet. The altitudes at which the other tests were administered is not included in the record, but I presume that those altitudes were less than 5999 feet.[30] The Claimant's recorded PCO_2 values ranged from a low of 42 to a high of 47.4. For those values, the qualifying PO_2 value is 60 at an altitude of 2999 or lower, and 55 at an altitude of 3000-5999 feet.

Based on the test results listed above, the Claimant attained a qualifying value for the test Dr. Perry administered in March 2006 during the course of medical treatment. He did not attain a qualifying value with the test Dr. Baker administered, and it is unclear whether he attained qualifying values in the remaining tests, because these results may or may not be qualifying, depending on the altitude at which they were conducted. The record is silent regarding the conditions under which Dr. Perry administered the arterial blood gas tests. Consequently, I give less weight to the results of his test than I give to the results of the other tests.

Because the record of arterial blood gas tests results is not conclusive, I find that the Claimant is unable to establish, by means of arterial blood gas test, that he is totally disabled.

Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. §718.204(b)(2)(iii). As stated above, I did not find that the Claimant had established the existence of pneumoconiosis. Moreover, there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment.

[30] Per 29 C.F.R. §18.201, judicial notice may be taken of adjudicative facts. The highest point in Kentucky is 4145 feet. See: http://www.geology.com/states/Kentucky.shtml.

Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. §718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

In his initial report, which reflected that the Claimant worked on a bolt machine and as a "machine operator," Dr. Baker opined that the Claimant had a "moderate to moderate severe" impairment based upon his pulmonary function and arterial blood gas test results and chronic bronchitis.[31] He also concluded that the Claimant's pulmonary diagnoses (COPD, chronic bronchitis, hypoxemia) all contributed "fully" to the Claimant's impairment. In response to a pre-printed question, "Does the miner have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment," Dr. Baker responded "No," citing the Claimant's pulmonary function test FEV_1 value (DX 14). In his follow-up response to the District Director, Dr. Baker stated that the Claimant's pulmonary impairment borders on severe, again citing the Claimant's FEV_1 value. Dr. Baker then concluded that this impairment is close to a 50% impairment of the Claimant's whole body, based on Guides to the Evaluation of Permanent Impairment. Dr. Baker again concluded that the Claimant does not have the respiratory capacity to continue in coal mine employment (DX 35 at 3).

In his medical report, Dr. Perry opined that the Claimant has a pulmonary impairment, caused by "coal dust exposure and tobacco use," and is unable to work as a coal miner due to his impairment. As a basis for his conclusion Dr. Perry's report stated that, among other things, the Claimant "has shortness of breath with minimal activity," and "scattered rhonchi," and that the Claimant's pulmonary function test results reveal moderate to moderate severe impairment (DX 15).

In both his reports, Dr. Dahhan concluded that, from a respiratory standpoint, the Claimant was disabled from employment as a miner due to his pulmonary disease (DX 35 at 149; EX 1). Dr. Dahhan's medical reports reflected that the Claimant had worked on a cutting machine, driving a truck, and on the tipple. In his report, Dr. Branscomb stated that the Claimant would not be disabled, from a pulmonary standpoint, from his most recent employment, as a truck driver, nor would the Claimant be disabled from other coal mine employment. Dr. Branscomb's conclusion was based on the pulmonary function test results he examined, which he noted reflected less than maximal effort, as well as Dr. Perry's 1998 note that the Claimant did not have difficulty breathing (DX 35 at 124).[32]

[31] Elsewhere in the report, in responding to a pre-printed question regarding the level of the Claimant's disability, Dr. Baker checked "moderate." The other choices were: no impairment, mild impairment, severe impairment, and totally disabled (DX 14).

[32] I did not consider Dr. Rosenberg's opinion, which was based on an assessment of medical records, because it exceeded the evidentiary limitations of §725.414.

Discussion

Of the foregoing physician opinions on disability, I find that Dr. Dahhan's opinion is well-reasoned, and I give it significant weight. Dr. Dahhan's conclusion, that the Claimant was disabled from coal mine employment due to his pulmonary impairment, is consistent with the results of the pulmonary function test that Dr. Dahhan himself administered. Additionally, Dr. Dahhan's report reflects that Dr. Dahhan was aware of the different types of jobs that the Claimant performed as a miner, which means that Dr. Dahhan was able to assess the Claimant's capabilities in light of the exertional requirements of these jobs.

I find Dr. Branscomb's opinion not to be well-reasoned on the issue of the Claimant's total disability, and I give it little weight. The record reflects that Dr. Branscomb assessed all the pulmonary function tests at issue in the Claimant's case. He rejected all of them as invalid, notwithstanding the fact that a Board-certified pulmonary physician validated one of the tests and that Dr. Dahhan, himself a Board-certified pulmonary specialist, conducted the other. Dr. Branscomb also mischaracterizes Dr. Dahhan's conclusions, stating that Dr. Dahhan determined that the Claimant had sufficient capability to continue as a miner when Dr. Dahhan stated the opposite. Moreover, Dr. Branscomb appears to have based his opinion at least in part on Dr. Perry's observation in 1998 that the Claimant did not have difficulty breathing, but did not consider Dr. Perry's conclusion that the Claimant could not work as a miner: the former piece of data, predating Dr. Branscomb's report by almost six years, is of little value on the issue of whether the Claimant is currently disabled. Lastly, Dr. Branscomb characterized the Claimant's last coal mine employment as "driving a truck." It is not clear whether Dr. Branscomb took into consideration the other exertional requirements of that job, as the Claimant explained in his testimony, or took into consideration the dust exposure inherent in that job.

Dr. Baker identified that the Claimant had a significant obstructive defect. Although his initial medical report was based, at least in part, on pulmonary function tests that were later invalidated, Dr. Baker's later statement to the District Director reiterates his conclusion, and specifically cites the second pulmonary function study, which Dr. Michos validated. I find, therefore, that Dr. Baker's conclusion is well-reasoned, and I give it significant weight.

Dr. Perry is the Claimant's treating physician and has treated the Claimant for a variety of problems for many years. His opinion, that the Claimant is unable to work as a miner, is based on pulmonary function test results. However, it is not clear which tests Dr. Perry relied upon, and whether they are the same tests that appear elsewhere in the record. In addition, it is not clear, from the record, whether Dr. Perry understood the exertional requirements of the Claimant's most recent coal mine employment. For these reasons, notwithstanding Dr. Perry's status as the Claimant's treating physician, I find Dr. Perry's opinion regarding the Claimant's disability not to be well-reasoned, and I give it little weight.

Based on the foregoing, therefore, I give the most weight to the opinion of Dr. Dahhan, followed by Dr. Baker. Both of these physicians have concluded that the Claimant is totally disabled, from a respiratory standpoint, from coal mine employment. Their conclusions cite objective medical test results (specifically, pulmonary function test results), and are consistent with the interpretation of those results. The record reflects that these physicians knew what the

Claimant's coal mine jobs were, and so were able to assess whether the Claimant was able to perform those particular jobs.

Consequently, I find that the Claimant has established, by a preponderance of evidence, that he is totally disabled, due to his pulmonary impairment, from coal mine employment. My finding is based on the totality of the evidence presented, including the physician opinions of record, as well as other objective evidence (such as pulmonary function test results).

d. Whether the Claimant's disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c); Grundy Mining Co. v. Flynn, 353 F.3d 467 (6th Cir. 2004); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. In general, the fact that an individual suffers or suffered from a totally disabling respiratory or pulmonary impairment is not, in itself, sufficient to establish that the impairment is or was due to pneumoconiosis. §718.204(c)(2). A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As set forth above, I have found that the Claimant is unable to establish that he has pneumoconiosis. Although I found that the Claimant has COPD, I also found that the Claimant was unable to establish that his COPD arose from his coal mine employment, as required under §718.201. Therefore, I find that the Claimant is unable to establish, by a preponderance of evidence, that his disability is due to pneumoconiosis.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established his entitlement to benefits under the Act.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

A

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.